STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
CS 4	CCRS must ensure consistent and timely adjudication of claims within contract requirements	Tucson Children's Clinics has been out of compliance for the timely adjudication of claims due to the implementation of a new claim system and a system conversion. Tucson Children's Clinic is currently in compliance with 90% of all claims adjudicated within 30 days of receipt and 99% of clean claims within 60 days of receipt. See attached CRS Paid Claims Aging Report. The attached Claim Adjudication Policy was revised to include a 48 hour turnaround time for other departments that must update the claim system if there are issues with eligibility or contracting. Tucson Children's Clinics will use the attached Claims Aging by Recipt Date Report that the Director of Healthcare Support runs daily to monitor claim turnaround time. Currently in compliance	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
CS 5	CCRS must clearly define within their policy the contract requirements for identifying and recouping erroneously paid claims	Overpayment/Underpayment & Recoupment Policy revised effective July, 2007. The revised policy outlines the process and procedures for identifying and recouping overpayments. Director of Healthcare Support Reviews the Overpayment/Underpayment Log & Claims Accuracy Report monthly. Effective 10/1/07 we will conduct monthly quality review by auditing 1% of examiner claims. Overpayment/Underpayment Log Monthly Review Claims Accuracy Report monthly. Review Policy Revision with Staff - Aug 5. In compliance.	
CS 7	CCRS must clearly define within their policy the contract requirements for identifying and reprocessing erroneously paid claims	The attached Claims Overpayment/ Underpayment and Recoupment Policy was revised effective July 31, 2007. The revised policy outlines the process and procedure for voiding and reprocessing of an encounter that was previously paid and or recouped. Effective immediately, the Director of Healthcare Support will monitor the Overpayment/Underpayment Log Monthly to ensure procedures outlined in revised policy are followed. Policy revisions were presented to the Staff on August 5, 2007. Due Date = Monthly. In compliance.	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
CS 13	CCRS must implement a policy or process to notify CRSA of any cumulative recoupment greater than $50,000 per provider per contract year	The attached Claims Overpayment/Underpayment and Recoupment Policy, effective July 2007, provides specific guidelines for notifying CRSA of any cumulative recoupment that will exceed $50,000 per provider per contract year. Policy & Procedure requires analysis of the overpayment and determination of recoupment amount prior to action. The attached CRS Over/under Claims Payments Report is forwarded to the Director of Healthcare Support immediately when the cumulative recoupment exceeds the threshold for notification to CRSA. The Policy revisions were presented to the Staff on August 5, 2007. Due Weekly. In compliance.	
CS 14	CCRS must implement a policy or process to request approval from CRSA prior to recouping monies from a provider later than 12 months after the date of original payment on a clean claim	See attached CRS Over/under Payments Report and revised Claims Overpayment/Underpayment and Recoupment Policy, effective July 2007, provides specific guidelines for obtain approval from CRSA prior to recouping from a provider monies later than 12 months after the date of the original payment on a clean claim. Policy & Procedure requires analysis of the overpayment and determination if recoupment from provider is beyond 12 months from the date of the original payment. If overpayment review confirms recoupment is beyond threshold of 12 months the file is forwarded to the Director of Healthcare Support immediately to obtain approval from CRSA prior to action to recoup. The revised Policy was presented to the Staff on August 5, 2007. Due date = Weekly. In compliance.	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
CS 8	CCRS must have policy and procedures consistent with contract requirements on reprocessing and paying all overturned claims disputes	The attached Claim Dispute Policy Revised July 2007 clearly defines the guidelines for reprocessing of overturned claims consistent with the decision within 10 business days. Effective immediately the Director of Healthcare Support will monitor the Provider Claims Dispute Log weekly to validate processing of any overturned claim within 10 days from the date of the decision. Due Date = Weekly. In Compliance	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
CS 10	CCRS must implement a comprehensive claims training policy by September 30, 2007	The attached revised Claims Training Policy, which was revised in July, 2007, was implemented prior to the September 30, 2007 deadline. Other attached supporting documents include: Tucson CRS Project Plan for Developing Claim Training Policy; Training Agenda; Claims Training Checklist; Upcoming Training Schedule; and Claims Processing Training Log. In compliance.	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
CS 12	CCRS must include all the information, as required in the contract, in the Remittance Advice	Programming was completed on April 30, 2007 to revise our Remittance Advice (attached) to ensure it includes the following requirements: descriptions of all denials, descriptions of all adjustments, the amount billed, the amount paid, and a statement addressing the providers' rights to file a claim dispute. In compliance.	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
CS14A	CCRS must implement a process to pay a slow payment penalty on hosp9ital clean claims I accordance with A.R.S. 36-2903.01 (unless otherwise specified in provider contract) by September 30, 2007	Facility claims are being paid timely within 60 days and have not been subject to this penalty. As part of our pre-payable close process, facility claims will be reviewed as to their timeliness of payment. Claims being paid in more than 59 days will be repriced to include a 1% penalty. (See Attachment A - Document Specs for CLM104R01V01). Hospitals will be notified of the potential penalty payment. All Clean claims are currently manually reviewed before payment is issued. The query to automate the facility claim review will be developed by August 10. A report will be developed to identify any clean claims paid outside the 60 days that have not had penalty applied by October 1.	
CS14A		Clean claims paid outside 60 days without penalty applied report will be run each payable close check date by the Claims Analyst.	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
CS 15	CCRS must implement a process and show evidence of receiving and paying at least 25% of all claims electronically (excluding claims processed by PBM).	Tucson Children's Clinics acknowledges the ADHS finding and has developed the attached Project Summary (Attachment CS 15 - A) and Project Plan (Attachment CS 15 - B) to accept inbound electronic claims. Tucson is also committed to reaching the 25% electronic reciept guideline and implement a solution to support electronic payment. This is a significant undertaking requiring coordination with providers, clearinghouses, and Plexis to develop and test. We anticipate completion of the technical components by 12/31/2007 with Plexis development costs of $100,000 and additional costs related to clearinghouse configuration and set-up. Note: Tucson will develop, test, and implement the appropriate mechanisms and processes to support inbound EDI and payment. Full compliance of this measure is dependent on the willingness of providers to submit electronic claims and the completeness and accuracy of data in their submissions.	
		As part of the Project Plan, a report will be developed to identify the volume of claims submitted on paper versus the volume of claims submitted electronically. The percentage of electronic claims will be calculated to determine level of compliance. The report will be executed at least monthly and distributed to the Director of Health Care Support.	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
FM1	CCRS must continue its efforts to resolve Plexis implementation issues including creating reporting tools that will satisfy the quarterly financial statement requirements	Children's Clinics does have a process to ensure its reporting requirements are accurate, timely and complete. The only component missing on the lag tables were extended months of IBNR due to Children's Clinic's need for a Plexis report. That report has been developed and the 3rd Quarter Financial Statements at 3/31/07 did have over 3 months of IBNR listed (See Attachment A - Current Estimate of Remaining Liability (RBUC & IBNR) line). CFO has always reviewed reporting requirements on a quarterly basis to ensure complete and accurate statements and will continue to do so. We will continue our current process	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
GS 1	CCRS must continue to provide members with written Notices of Action and/or Notices of Extension the meet required format standards	CCRS will continue to provide members with written Notices of Action and/or Notices of Extension that meet required format standards	
GS 1		We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews every letter to the member for format. If there is a problem with the format, the letter is revised before it is sent	
GS 2	CCRS must provide members with written Notices of Action that meet required content standards.	CCRS will continue to provide members with written Notices of Action that meet required content standards	
GS 2		We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews every letter to the member for content. If there is a problem with the content, the letter is revised before it is sent	
GS 3	CCRS must provide members with written Notices of Action within the required timeframes	CCRS will provide members with written Notices of Action within the required timeframes	
GS 3		We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews the timelines to be sure that the required timeframes have been met. If there is a problem, it is addressed immediately	

GS 4	CCRS must provide the member with a written Notice of Extension when taking more than 14 (standard) or 3 (expedited) working days to decide initial request for service authorization, or when it determines that the service requested is not a CRS covered benefit, and refers the request to the member's primary AHCCCS plan	CCRS will provide the member with a written Notice of Extension when taking more than 14 (standard) or 3 (expedited) working days to decide initial request for service authorization, or when CCRS determines that the service requested is not a CRS covered benefit, and refers the request to the member's primary AHCCCS plan	
GS 4		We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews the Notice of Extension to be sure that the timelines are met. If there is a problem, it is addressed immediately	
GS 4a	CCRS must provide members with written Notices of Extension that meet required content standards	CCRS will provide members with written Notices of Action that meet required content standards	
GS 4a		We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews the Notices of Extension to be sure that they meet the required content standards. If there is a problem with content, the letter is revised before it is sent	
GS 4b	CCRS must provide timely, written notification to the member's primary AHCCCS plan it determines that the service requested is not a CRS covered benefit	CCRS will provide timely, written notification to the member's primary AHCCCS plan when CCRS determines that the service requested is not a CRS covered benefit	
GS 4b		We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews the letter to the member's primary AHCCCS plan to be sure that the required timelines are met. If there is a problem, it is addressed immediately	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
GS 6	CCRS must maintain and implement a grievance process which documents, monitors, intervenes, and reports Non-QOC grievance occurrences	Children's Clinics has revised it's Grievance Policy (attached) to comply with these requirements (see "Procedures; 5. Basic resolution process; "m"). All QOC and Non-QOC issues will be entered in the grievance log and reported to ADHS/CRSA monthly which will include intervention strategies. Summary of grievance log and process is reported to UM/QM Committee quarterly. Trends will be noted and action taken if necessary.	
GS 6	CCRS Grievance Policy must contain a provision that the member may file a grievance with CRSA or the regional contractor to the Grievance Policy	Children's Clinics has revised it's Grievance Policy to comply. (Procedures ; 3. Filing; "b"). Members to be informed of Grievance Policy in Intake Packet, and Patient Rights posted on the website and through out the clinic. UM/QM Committee to review Grievance Policy annually or as needed. Substantial revisions will be communicated to appropriate individuals.	
GS 6	CCRS must define "grievance" in its Grievance Policy as a CRS member's expression of dissatisfaction with any aspect of their care, other than the appeal of actions	Children's Clinics has revised it's Grievance Policy to comply. (Policy; second paragraph).	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
GS 21	CCRS must comply with claims dispute requirements related to timely written acknowledgment and decisions	Tucson Children's Clinics developed an acknowledgement letter (an example is included in the Claim Dispute Policy as attachment B) that was approved by CRSA. See Exhibit B for GS21. Acknowledgement letters have been in production since June, 2007. Due date = weekly. In compliance.	
GS 22	CCRS claim dispute notices of decision must include all required information	The attached Claim Dispute Policy was revised April 2007. It clearly defines required information. Director of Healthcare Support reviews required information weekly during Claims Review. Currently in compliance.	
GS 23	CCRS must have a process of consistently recording and maintaining records of claims disputes	The attached Claims Dispute Policy was revised April 2007. It clearly defines the guidelines for recording and maintaining claim disputes. Claim disputes are recorded on the claim dispute log as soon as they are received. Paper records are filed in the Claims Department. Both the provider dispute log and the paper files are faxed to CRSA monthly. Director of Healthcare Support reviews disputes weekly during Claims Review. In compliance.	
GS 24	CCRS must maintain evidence in the claims dispute case records that denied claims reversed in the claims dispute process are paid within 10 business days of the date the denial is reversed	The attached revised CRS Claims Overpayment/Underpayment and Recoupment Policy effective July 2007 provides specific guidelines for notifying CRSA of any cumulative recoupment that will exceed $50,000 per provider per contract year. Policy & Procedure requires analysis of the overpayment and determination of recoupment amount prior to action. The attached CRS Over/ Underpayments file is forwarded to the Director of Healthcare Support immediately when the cumulative recoupment exceeds the threshold for notification to CRSA. Due date = weekly. In compliance 11/01/2007.	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
MM 1	CCRS must ensure full implementation of utilization management program requirements	CCRS has developed a new process for utilization management. This process is detailed in our Utilization Management/Quality Management (UM/QM) Committee Policy (attached)	
MM 1		Dr. Ghory is responsible for the Utilization Management portion of the monthly UM/QM team. She will report quarterly to the Senior Leadership Team. Compliance recommendations will be made at that time.	
MM 1	CCRS must develop policies and procedures for monitoring inpatient, ambulatory surgery, outpatient, and other services by gathering data, identifying trends, implementing interventions, and analyzing the results of actions taken	Aggregate data is currently being collected regarding inpatient stays, ambulatory surgical procedures, other outpatient procedures and other services. This data will be addressed in the UM/QM Committee, as per our Utilization Management/Quality Management (UM/QM) Committee Policy (attached). Periodically, policies and procedures for more extensive monitoring and analysis of data will be developed by the UM/QM Committee. These policies and procedures will be presented to Senior Leadership Team	
MM 1	CCRS must discuss these activities in regularly scheduled meetings attended by appropriate staff, and reflect discussions, with action items, in the meeting minutes	UM/QM meetings are scheduled monthly, as detailed in the Utilization Management/Quality Management (UM/QM) Committee Policy (attached). Appropriate staff will be invited, according to the topics to be discussed. Minutes will detail discussion and action items	
MM 1		Dr. Ghory is responsible for the Utilization Management portion of the monthly Utilization Management/Quality Management (UM/QM) Committee. She will report quarterly to the Senior Leadership Team, using minutes from the UM/QM meetings. Compliance recommendations will be made at that time	

MM 2	CCRS must discuss medical/utilization management issues regularly, including data analysis, identification of trends and variances, implementation of interventions, and review of recommendations	UM/QM meetings are scheduled monthly, as detailed in the Utilization/Quality Management (UM/QM) Committee Policy (attached). The discussion will include data analysis, identification of trends and variances, implementation of interventions, and review of recommendations	
MM 2	CCRS must document these discussion in committee minutes.	Minutes will be recorded at all UM/QM meetings	
MM 5	CCRS must clearly document/identify the reasons for requesting the extension	Notices of Extension for Service Authorization Timeframe will document clearly the reasons for requesting the extension	
MM 5		We will monitor weekly through our denial logs. When Dr. Ghory reviews the denial log, she reviews every letter to the member for content. If a letter of Notice of Extension for Authorization Timeframe is not clear about the reasons for requesting the extension, the letter is revised before it is sent	
MM 5	CCRS must document the role of Dr. Ghory as designee to the Medical Director	In order to clarify the role of Dr. Ghory, her title has been changed from "Medical Consultant" to "Medical Director for Utilization Management." This change is reflected on her Job Description and on the Organization Chart. Her duties, as listed on her Job Description, did not change	
MM 5		Now we are at full compliance. See attached Job Description for Dr. Ghory and CCRS Organization Chart	
MM 6	CCRS must arrange inter-rater reliability (IRR) training and testing for all staff involved in determining medical necessity, including the Medical Director	IRR training and testing occurs for all staff involved in Prior Authorization, Concurrent Review and Retrospective Review during the Case Review Committee, at least annually, and as needed, if there are issues and/or if there is a change of staff. (See IRR Policy, attached.) The Case Review Committee will monitor this process and this will be reflected in the minutes of that committee	

MM 6	CCRS must conduct regular checks for consistent application of IRR review criteria and document the findings	Bi-monthly monitoring of the consistent application of IRR review criteria occurs at Case Review. This will be documented in the minutes	
MM 6	CCRS must require that their Prior Authorization Review Specialist be an Arizona-licensed registered nurse, physician or physician's assistant	Our RN Utilization Coordinator is a Arizona-licensed registered nurse. See attached Prior Authorization Policy	
MM 6-A	CCRS must conduct regular checks for consistent application of review criteria for IRR and document the findings	Bi-monthly monitoring of the consistent application of IRR review criteria occurs at Case Review. This will be documented in the minutes	
MM 6-A	CCRS must document the action taken when criteria are not being applied in a consistent manner	When criteria are not being applied in a consistent manner, IRR training and testing will be repeated. (See IRR policy, attached.)	
MM 6-A		Dr. Ghory, as the Medical Director for Utilization Management, will make sure that repeat training and testing has been completed.	
MM 7	CCRS must document the action taken when criteria are not being applied in a consistent manner	When criteria are not being applied in a consistent manner, IRR training and testing will be repeated. (See IRR policy, attached.)	
MM 7		Dr. Ghory, as the Medical Director for Utilization Management, will make sure that repeat training and testing has been completed	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
MM 4	CCRS must reflect and reference in its Clinical Practice Guideline policy how it implements the guidelines and monitors their use	The Medical Management/Clinical Practice Guideline Policy is attached. When the final copy of the clinical practice guidelines were posted on the CRS web site, they were e-mailed to all providers and staff who are directly involved with those specialty areas. Other providers may request copies and this will be communicated in the Provider Manual. The Clinical Practice Guidelines are also posted on the Children's Clinics web site. In-clinic practitioners may access the guidelines in the on-line library. Staff working in those clinics are also given copies of the guidelines.	
MM 4		The Medical Directors are compiling a list of indicators for each guideline (see attached document entitled "Review Measures for Clinical Guidelines". Records of members who are covered under a specific guideline will be reviewed using the indicators chosen by the Medical Directors. This review will be completed at least annually on each practice guideline. Review results will be presented at the quarterly Medical Executive Committee meeting.	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
MM 10	CCRS must document the name of PCP on each member record/file; additionally, coordination of care with member PCP must be documented as well	As we identified a discrepancy between documentation of the patient's correct PCP on the Patient Data Form and our computer system, we implemented a system whereby the PCP information will be removed from the Patient Data Form (yellow) in each patient chart. This transition will be addressed in the following manner: 1) PCP information will be transferred to the patient contact form (green form) by the clinical staff, and taken to the front desk to be entered in the computer system; and 2) The name of the PCP will be crossed out on the patient data form (yellow form) once transferred to the patient contact form (green)	
MM 10		Auditing/Monitoring of the process identified above: every three (3) months the Medical Records Manager will perform a random review of fifty (50) medical records of members who have attended recent clinic appointments to confirm that the name of the PCP has been removed from the Patient Data Form (yellow) and is accurate on the PTF (Patient Transaction Form)	
MM 10		The name of the member's PCP is documented in the computer system and this information will be verified with the patient/guardian at every visit and when there is phone contact between a provider and a member. If there are changes in PCP information, a patient contact form (green) will be completed and sent to the front desk to change in ADT and then to enrollment to change in Plexis. The name of PCP will then appear on every PTF (patient transaction form) that is maintained in the chart	
MM 10		Auditing and monitoring of process identified immediately above: Patient contact form (green) is initialed once information is entered into the computer system and audited on a weekly basis by healthcare support	

MM 10		Coordination of care with the PCP is documented in the chart through notation of a cc to the PCP on each clinic note, including rehab appointments. We plan to form a Coordination of Care PI Team in the next quarter to identify other processes in which we can improve our coordination of care efforts and procedures	
MM 10		When a member is transferred to another regional provider the PCP will receive a copy of the regional transfer form. The Medical Records Manager will audit the Correspondence Log every three (3) months to ensure all PCPs receive a copy of the Regional Transfer Form on their transferred patients	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
MS4	CCRS must document the member's decision about whether to develop (execute) an advance directive in the member's medical chart	To comply with contractual requirements, charts of all members 18 years of age and older were reviewed to ensure that the medical record documented if an Advance Directive (A.D.) was present or not on the member's chart. The charts of new members will be reviewed quarterly and the presence or absence of an A.D. will be recorded on the Patient Summary sheet (Attachment 3).	
		As part of the Enrollment and Transition process, all members and new enrollees ages 18 and older will be asked if they have or wish to execute an A.D. The response of new members and their decision to execute an A.D. are documented on the "Welcome to the Children's Clinics" form (Attachment 1), and placed on the medical chart. Existing members will also be asked the same questions as the new enrollees and will have their responses documented on the Transition form (Attachment 2) and the Patient Summary sheet in the medical record. In both situations enrollees and members will be asked to bring in an A.D. if they have executed one and the clinic does not have a copy in the medical record and/or will be given information about A.D. and any assistance as needed. This will be documented on appropriate forms.	
		Our amended policy (attached) gives detailed information to include staff responsibilities. Policy RI.004-Advanced Directives	
		Chart location of documents: Advance Directive (Under the Consent tab); Patient Summary sheet (right inside front); Intake Acknowledgement Letter (Correspondence tab); Transition form (Transition tab)	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
NS 1	CCRS must complete the approval for and implementation of their new policy MS.001. Process for Notification of Change in Provider(s) or Changes in Program.	Policy for "Maintaining the Provider Network", was approved, signed by the CEO, implemented, and attached to this CAP. The new Policy entitled "Process for Notification of Change in Provider(s) or Changes in Program", has been signed by the CEO and implemented (attached to this CAP). Changes requiring future revisions to these policies and letters shall be made to comply with future regulatory changes/requirements when appropriate.	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
NS 2	CCRS must have a written policy/procedure for provision of second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network at no cost to members	Second Opinion Policy (attached) addresses all these items. We are in full compliance	
NS 3	CCRS must create a separate written policy/procedure for out of state/network services. Policy should discuss the availability for second opinion at no charge to member (in or out of network); as well as describe how out of network providers coordinate payment with CCRS	Out-of-State/Out-of-Network Providers (attached) addresses all these items. We are in full compliance	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
QM 4	CCRS must establish a policy/process for monitoring its delegated entities on an ongoing basis and review them formally at least annually	Our policy, entitled "Monitoring of Delegated Entities" (attached) identifies the Clinic's procedures for monitoring delegated entities and contracts, including formal review of delegated services. A list is maintained which identifies all delegated service/entities and the functions and/or services delegated to these entities by Children's Clinic. The process addresses all contracted or "delegated" services delivered to Clinic patients, such as DME, pharmacy, or laboratory services. Individual providers are not included within the scope of the term “delegated agreements” within this policy. Delegated contracts shall contain provisions of quality monitoring as well as provisions for revocation of the contract for inadequate performance of the delegated duties	
QM 4		The list of delegated services and entities are monitored on an ongoing basis by the Director Compliance/QA to ensure accuracy and identification of reported or suspected quality issues or concerns relating to the delegated services. Prior to delegation of functions to an entity, we ensure that the entity is capable of providing the delegated services for which we are entering into the contract	
QM 4	CCRS must have a contract for all functions or responsibilities delegated to the entities	Utilizing our list of delegated services, we verified that we have contracts with for all delegated services with the exception of LabCorp. We have been communicating with LabCorp the need for a formal contract. We have sent them a contract to sign to ensure compliance with this requirement. We monitor the list on ongoing basis to ensure signed contracts are on file for all delegated services	

QM 4	CCRS must ensure that the subcontractor implements corrective action if any deficiencies are identified	Potential quality issues are identified by ongoing review of input from providers, patients, and employees regarding services to Clinic patients performed by delegated entities. Examples of processes monitored on an ongoing basis to capture complaints and/or concerns include: 1) The grievance log to identify complaints/ concerns; 2) Performance measures identified in the contact with the entity to ensure compliance with standards; and patient surveys. Potential quality concerns are reported to, and addressed, by the UM/QM Committee	
QM 4	CCRS must have evaluation reports and CAP documentation, as necessary, to ensure quality for all delegated activities	Reports evaluating the quality of services rendered by entities providing delegated services, including any corrective action plans, are presented to the UM/QM Committee every quarter, with individuals concerns being presented to the UM/QM Committee at the regularly-scheduled meeting of the Committee following a reported concern or event. Activities of individual providers (Medical and Allied Staff) are reviewed and addressed, as needed, through the Medical Staff Peer Review process and the Case Review Committee. The UM/QM Committee oversees and is accountable for any activities that are delegated and provided by entities outside the Clinic	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
QM 5	CCRS must include a requirement in its quality of care policy that staff enters all QOC's and Non-QOC's in the QOC data base	Children's Clinics has revised it's Grievance Policy to comply (Procedures; 4. Basic administrative processes for handling grievances; "e").See attached Grievance Policy. Other Clinic employees have been cross trained in maintaining and documenting the data base to cover this activity when the Manager of Patient and Family Service is out of the office. Periodic reminders are sent to all Clinic staff members reinforcing the need for them to submit all (QOC and non-QOC) to the Manager to enter into the data base.	
QM 5	CCRS must include definitions of "non-QOC concerns," "QOC concerns," "substantiated," "unsubstantiated," "unable to substantiate," "corrective action plan" and "severity levels 0-4" in its quality of care policy.	Children's Clinics has revised it's Grievance Policy (attached) to comply. Non-QOC and QOC definitions: (Procedures; 4. Basic administrative processes for handling grievances; "c").Substantiated, unsubstantiated, unable to substantiate are defined in Attachment # 12; Corrective action plan definition (Procedures; 5. Basic resolution process; "k"). Severity levels defined in Attachment # 10 in the Grievance Policy	
QM 5	CCRS must have a process for monitoring quality of care that includes reporting quality of care concerns from anywhere in the CCRS managed care system (e.g. providers, delegated services, acute hospitalizations, UM/case management review).	Please see response to QM 4 re: delegated services	

STNRD#	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
QM 7	CCRS must maintain a performance score of 75% or higher on all performance measures	A multidisciplinary Team (minutes and sign in sheets available) was formed, met several times, and analyzed timeframe performance measures of: 1) preliminary eligibility; 2) preliminary ineligibility; 3) incomplete referral form; 4) timeliness of initial evaluation; and 5) first appointment with CRS specialty provider. Results: New tracking forms were developed and implemented to ensure applications are processed within specified timeframes; letters were revised to ensure compliance with RCPPM Chapter 20; a process for ongoing monitoring of reports was implemented to indicate "day calculations" to allow time for intervention (prior to exhaustion of timeframes) to ensure ongoing compliance with performance standards; and our scheduling process was redesigned for continuity of scheduling. Compliance percentages of the five performance indicators (listed above) are reported and analyzed at each meeting of the UM/QM Committee	
		Clinic compliance percentages for the five required performance indicators for June, 2007 and July, 2007 (respectively) were: Preliminary eligibility = 100% and 100%; preliminary ineligibility = 97% and 88%; incomplete referral forms = 97% and 85%; timeliness of initial evaluation = 98% and 100%; and first appointment with CRS specialty provider = 100% and 98%	

QM 7	CCRS must ensure accuracy of the performance measure data submitted	A meeting was held, including the IT Department staff, to ensure all employees involved in data submission and analysis (of reports, data entry, and components utilized to calculate the Clinic's compliance percentages for performance measures), are aware of the data parameters, the reports generated, and the elements utilized to measure compliance. Results: A process was developed which allows for more timely access and printing of reports. A group was also organized that will meet in the event data reveals any issues in the Clinic maintaining compliance with the performance standards. This group will proactively interact with Staff to ensure continued compliance as needed	

x	ADHS Findings	Children's Clinic Comments and/or Recommendations	ADHS Comments
QM 11	CCRS must ensure that consultation report is sent to both referring physician and health plan/contractor within 30 days of the first clinic visit and documented in medical records.	All intake reports (initial clinic visits) are sent to the Clinic's Medical Records Department who sends copies of the visit report to the members' PCP and health plan within thirty (30) days of the visit. Evidence of the mailings are documented in the Correspondence Log, located in the Medical Records Department. The Medical Records manager will audit the Correspondence Log on a monthly basis to ensure compliance. Staff will be educated on an ongoing basis as needed.	.
		The names of the PCP and health plan are noted as a cc on the bottom of the intake clinic report. Those are also found on the correspondence log found in medical records. The Medical Records manager will review ten percent (10%) of intake reports (initial Clinic visit) every month to confirm that the names of the PCPs and health plans are noted as a "cc" at the bottom of the intake clinic reports. Staff will be educated as needed.	

QM 11	CCRS must ensure that the approval notices to both the referring physician and health/plan program contractor are sent within 10 working days and are documented in the medical record.	Approval notices are sent to the referring physician and the health plan/ program within ten (10) working days and a copy is filed in the medical record (located behind the "correspondence" tab).	
QM 11	CCRS must ensure that eligibility denial notifications are sent to both the referring physician and health plan/program contractor within 5 working days denial determination and are documented in the medical record.	Denial notifications are sent to referring physician and health plan/program within five (5) working days, and a copy is filed in the patient's medical record (located behind the "correspondence" tab).	
